New Hampshire Adult Tobacco Survey, 2002

New Hampshire Department of Health and Human Services
Office of Community and Public Health
Tobacco Prevention and Control Program

New Hampshire Adult Tobacco Survey, 2002

William J. Kassler, MD, MPH
State Medical Director
New Hampshire Department of Health and Human Services

Prepared by:
Ludmila Anderson, MD, MPH
Susan Knight, MSPH
Elizabeth Peterson, MPH
New Hampshire Department of Health and Human Services
Office of Community and Public Health
Chronic Disease Prevention
Tobacco Prevention and Control Program

August 2003

For additional information on the New Hampshire Adult Tobacco Survey, 2002:
New Hampshire Department of Health and Human Services
Office of Community and Public Health
Tobacco Prevention and Control Program
29 Hazen Drive
Concord, NH 03301
Phone: 603.271.6891 or 1.800.852.3345 ext. 6891
TDD Access: 1.800.735.2964

Table of Contents

Acknowledgements 4

Introduction 5

User's Guide to this Report 10

Frequently Asked Questions 11

2002 NH ATS Results 13

1. Tobacco Use 13

2. Cessation 16

3. Secondhand Smoke 19

4. Risk Perception and Social Acceptability 23

5. Policy Issues 26

6. Parental Involvement 27

7. Media 28

References 29

Appendix A: Definitions 31

Appendix B: 2002 NH ATS Questionnaire 33

Acknowledgements

ORC Macro, Inc.:
James Dayton
Kirsten Ivie
Will Robb

Centers for Disease Control and Prevention:
Peter Mariolis, PhD
Heather Ryan, MPH
Karen Seiner, MPH

Reviewers:
Andrew Pelletier, MD, MPH, NH Tobacco Prevention and Control Program
Leigh Ramsey, PhD, NH Tobacco Prevention and Control Program
Beth D'Ovidio, BA NH Tobacco Prevention and Control Program

Contributors:
Aviva Meyer, MPH, NH Tobacco Prevention and Control Program

Introduction

This report provides the results of the 2002 New Hampshire Adult Tobacco Survey. It gives the reader a comprehensive look into adult behaviors, attitudes, and use of tobacco products in New Hampshire.

NH Tobacco Prevention and Control Program

The New Hampshire Tobacco Prevention and Control Program was organized in 1995 as part of a national effort to develop state-level capacity to address tobacco use. For the first five years of the program, funding was from the Centers for Disease Control and Prevention, Office on Smoking and Health.

In 1999, the New Hampshire Legislature enacted RSA 126-K that established the Tobacco Use Prevention Fund. This legislation directed that a portion of New Hampshire's Master Settlement Agreement be allocated yearly to this fund. These additional funds enhanced the efforts of the New Hampshire Tobacco Prevention and Control Program and corresponded with the release of the New Hampshire Comprehensive Tobacco Prevention and Control Plan in 2000. This Plan endorsed and incorporated the comprehensive tobacco prevention and control efforts recommended by the Centers for Disease Control and Prevention, including:

Community Programs	Statewide Programs
School Programs	Cessation Programs
Enforcement	Counter-Marketing
Surveillance and Evaluation	Administration and Management

Data from California and Massachusetts have shown that implementing a comprehensive tobacco control program produces substantial reductions in tobacco use. Evaluation is crucial in assuring that programs are achieving their stated objectives. Surveys, which monitor behaviors, attitudes, and health indicators at regular intervals over a period of time, enable the New Hampshire Tobacco Prevention and Control Program to target resources and evaluate progress.

Prior to 2002, the only information available on New Hampshire adults' behaviors, attitudes, and use of tobacco products was from the Behavioral Risk Factor Surveillance System and the Current Population Survey. In the summer of 2002, the Adult Tobacco Survey (ATS) was fielded for the first time in New Hampshire. The ATS provided more in-depth information on adults' behaviors, attitudes, and use of tobacco products than either the Behavioral Risk Factor Surveillance System or the Current Population Survey.

ATS Methodology

The New Hampshire Tobacco Prevention and Control Program oversees ATS question inclusion, sample size determination, contracts for interviewing and data collection, and data analysis. Interviewing, data collection, data processing, and data analysis were carried out by ORC Macro, of Burlington, VT.

Survey Instrument

The survey instrument consisted of 103 questions focused on different aspects of adults' behaviors, attitudes, and use of tobacco products. The instrument was developed by the Centers for Disease Control and Prevention, with assistance from other states who had conducted similar adult tobacco surveys. Questions used in the NH ATS were drawn from a

core set of questions, intended to be used by each state, and an optional question set that states may choose from to meet their specific needs. New Hampshire added additional state specific questions. The questionnaire was divided into the following sections:

Demographic Items
Tobacco Use
Cessation
Secondhand Smoke
Risk Perception and Smoking Influences
Policy Issues
Parental Involvement
Media Exposure

The questions asked of respondents varied according to their smoking status (current smoker, former smoker, or non-smoker) and various other screening criteria. The average interview took approximately fourteen minutes.

Survey Population

The population surveyed for the NH ATS was the total, non-institutionalized, adult population residing in telephone-equipped dwelling units in the state of New Hampshire. This population excludes adults who were:

- in penal, mental, or other institutions;
- in other group quarters such as dormitories, barracks, convents, or boarding houses (with ten or more unrelated residents);
- contacted at their second dwelling unit during a stay of less than 30 days (vacation homes); or
- in a dwelling unit without a telephone.

Interviews were only conducted in English, so individuals who did not speak English well enough to be interviewed were also excluded.

The NH ATS called for a probability sample of all households with telephones in New Hampshire, with a minimum of 3000 completed interviews. To accomplish this, ORC Macro implemented a disproportionate stratified random digit-dialed sample design based on a list-assisted frame, following sampling protocols recommended by the Centers for Disease Control and Prevention for the Behavioral Risk Factor Surveillance System.

An up-to-date list of all current operating telephone exchanges (three-digit prefixes) was identified within New Hampshire and combined with all four-digit numbers from 0000-9999. As area codes and exchanges follow state boundaries with no overlap, this constituted the set of all possible working telephone numbers in the state, both residential and non-residential. The set of possible telephone numbers was then arranged in ascending order by exchange and four-digit suffix, and divided into "blocks" of 100 numbers each, based on the first two digits of the suffix.

These blocks of numbers were compared against cross-reference directories to determine which blocks contained at least one known residential listing. Blocks that contained no known working residential numbers (called "zero-blocks") were excluded from the sampling frame to improve dialing efficiency. A total of 18,050 numbers were called to yield 3,000 completed interviews.

The final stage of sampling involved the use of a household roster to randomly select an adult respondent. Interviewers asked the number and gender of all adults in the household, and a computer software program automatically selected the respondent to be interviewed.

Interviewing Procedures

Between August 15 and October 28, 2002, 3,000 random-digit-dialed selected New Hampshire adults participated in the ATS. Experienced, supervised personnel conducted interviewing using computer-assisted telephone interviewing technology. Fifteen attempts were made to reach a respondent for each selected telephone number. Attempts were rotated across daytime, evening, and weekend hours, to maximize response rates.

Each phone call made received a disposition code. A disposition code defines the final result of the call. Table 1 lists the disposition codes used in the ATS.

Table 1. Disposition Codes, 2002 NH ATS.

ATS Disposition Codes
01 = Completed interview
02 = Refused interview
03 = Non-working number
04 = Ring-no-answer
05 = Not a private residence
06 = No eligible respondent at this number
07 = Selected respondent not available during time period
08 = Language barrier
09 = Interview terminated within questionnaire
10 = Line busy
11 = Respondent unable to communicate due to physical or mental impairment
12 = Technological barrier
13 = Never call list
14 = Hang-up

Three response rates for the ATS were calculated based on these disposition codes: the CASRO (Council of American Survey Research Organizations), upper bound, and lower bound response rates. The CASRO response rate calculates the rate at which interviews were obtained among all identified, potentially eligible respondents, plus those households where eligibility could not be determined. The NH ATS CASRO response rate was 52.6%. The upper bound response rate, also known as the cooperation rate, measures the level of cooperation attained among identified, eligible, and capable respondents and excludes respondents who did not complete the interview for reasons other than refusing to cooperate. The upper bound response rate was 66.2%. A final response rate, called the lower bound response rate, measures the efficiency of the sample frame. This lower bound response rate is calculated by dividing the number of completed interviews by the entire sample size. This rate was 16.6%.

Data Processing and Weighting

The survey program contained logic and range checks to eliminate sources of error at the point of entry. At the end of the interviewing period, the data were converted into ASCII files, and SAS systems files were constructed to identify and clarify logically inconsistent responses (similar to the PC-Edits program designed by the Centers for Disease Control and Prevention for the Behavioral Risk Factor Surveillance System).

Data were weighted to make the ATS results more representative of the population of New Hampshire, using the 2000 Census parameters of age and gender. The weighting formula also accounted for the selection probability, taking into account the number of adults living in the household, and the number of phone lines in the house.

Table 2. Weight Variables, 2002 NH ATS.

Demographic	Unweighted Frequency	Unweighted Percent	Weighted Percent Percent	2000 NH Census Census
Gender				
Male	1,259	42.0	48.5	49.2
Female	1,741	58.0	51.5	50.8
Total	**3,000**			
Age				
18-24	170	5.8	11.3	11.2
25-34	474	16.2	17.1	17.3
35-44	704	24.0	24.0	23.9
45-54	619	21.1	20.0	19.9
55-64	440	15.0	11.8	11.8
65+	525	17.9	15.9	16.0
Total	**2,932**			

Data analysis was done in SAS (version 8; SAS Institute Inc. Cary, NC) and SUDAAN (Software for the Statistical Analysis of Correlated Data, Research Triangle Institute (2001).

Respondent Demographics

The following table presents respondent demographic variables.

Table 3. Respondent Characteristics

Demographic	N	Weighted Percent	95% CI
Gender			
Male	1,259	48.5	46.5-50.5
Female	1,741	51.5	49.5-53.5
Total	**3,000**		
Age			
18-24	170	11.3	9.5-13.0
25-34	474	17.1	15.6-18.6
35-44	704	24.0	22.3-25.6
45-54	619	20.0	18.4-21.5
55-64	440	11.8	10.7-13.0
65+	525	15.9	14.5-17.3
Total	**2,932**		
Race			
White	2,816	95.2	95.3-96.1
Non-White and/or Hispanic	131	4.8	3.9-5.7
Total	**2,947**		
Income			
Less than $20,000	288	9.1	7.9-10.3
$20,000-$34,999	525	19.5	17.8-21.2
$35,000-$49,999	464	18.5	16.9-20.2
$50,000 and higher	1,255	52.9	50.1-55.0
Total	**2,532**		
Education			
Less than high school	188	6.2	5.2-7.2
HS or GED	836	29.4	27.5-31.2
Post high school	1,976	64.4	62.5-66.4
Total	**3,000**		
Marital Status			
Married	1,712	63.7	61.8-65.7
Divorced	411	9.5	8.5-10.5
Widowed	291	6.1	5.4-6.9
Separated	51	1.4	0.9-1.9
Never married	398	13.4	13.6-17.0
Member, unmarried couple	105	3.5	3.1-4.8
Total	**2,968**		
Lives With a Child Under 18 Years of Age			
Lives with child	1,113	40.9	38.9-42.9
Does not live with child	1,887	59.1	57.1-61.1
Total	**3,000**		

User's Guide to this Report

This report is organized into three major sections: an executive summary (published as a separate document), the main report, and appendices. The executive summary is a smaller version of the report, summarizing New Hampshire adults' behaviors, attitudes, and use of tobacco products reported from the 2002 NH ATS. It is intended to stand on its own as a synopsis of the data.

The main report is organized into eight subsections and includes detailed charts and tables. Where appropriate, the tobacco-related objectives from *Healthy People 2010* and *Healthy New Hampshire 2010* are included to put current data into perspective. *Healthy People 2010* is a set of national health targets for the next decade while *Healthy New Hampshire 2010* objectives are specific to New Hampshire residents. The data in this report can be used in assessing progress towards *Healthy People 2010* and *Healthy New Hampshire 2010* objectives along with the goals of the New Hampshire Tobacco Prevention and Control Program.

Appendix B includes a copy of the questionnaire.

Sampling Error and Confidence Intervals

In this report, 95% confidence intervals (95% CI) are presented along with point estimates (percentages). Because survey data are collected from a sample of the population, each percentage is actually an estimate of the true value and has a margin of error or, "Confidence Interval." The confidence interval reflects the degree of uncertainty for each estimate. For example, Figure 1-1 shows that 17.9% of New Hampshire residents sampled in the 2002 ATS reported being current smokers, with a 95% confidence interval of 16.3%-19.5%. This means that our best estimate of the percentage of current smokers is 17.9% but that the true value could be as low as 16.3% or as high as 19.5%. In other words, this estimate has a margin of error of +1.6%.

Sample Size or "N"

In each table, the N represents the number of individuals responding. For example, in Table 3, the N for the 18-24 year old age group is 170. This means that 170 individuals answered the age question with a response between 18 and 24 years. The Total for the Age category is 2,932. This means that only 2,932 out of the 3,000 respondents completing interviews answered the age question. Sixty-eight respondents declined to answer.

Graphs

Graphs have varying scales adjusted for the data displayed. This should be kept in mind when making comparisons between graphs.

Frequently Asked Questions

Current smokers are referred to throughout the report. What is the definition of a current smoker?

A current adult smoker is defined as someone who has smoked at least one hundred cigarettes in his or her lifetime and now smokes cigarettes everyday or some days.

How does this survey compare to the Behavioral Risk Factor Surveillance System survey?

Although many questions asked on the NH ATS are similar to the questions on the Behavioral Risk Factor Surveillance System survey, results from the two surveys should not be compared. The surveys differ in the timeframe in which they were administered, introductory language and the placement of questions.

Why are data not presented by race or ethnicity?

Based on the 2000 United States Census, New Hampshire's population is approximately 96.0% White, 1.2% Asian, 0.7% Black/African American, 0.2% American Indian/Alaska Native, and 1.8% persons reporting some other race. About 1.6% of the population is of Hispanic or Latino origin. Because no single racial or ethnic minority group exceeds 1.7% of the total population, the number of respondents in these groups is too small to report for meaningful analysis. As the state's demographics change and as data collection techniques improve, it may be possible to present data on racial and ethnic minorities in the future.

How do I know if differences are statistically significant?

In this report, if the confidence intervals for two percentages do not overlap, their difference is considered to be statistically significant.

What are the Centers for Disease Control and Prevention?

The Centers for Disease Control and Prevention are part of the United States Department of Health and Human Services. The Centers for Disease Control and Prevention is considered the nation's prevention agency; it focuses on public health measures to prevent disease, disability, and death. The national tobacco control program, which is part of the Centers for Disease Control and Prevention, Office on Smoking and Health, has developed recommendations for states on how to control tobacco use. New Hampshire, like many other states, has built its tobacco control program using the Centers for Disease Control and Prevention recommendations. The Centers for Disease Control and Prevention recommends a comprehensive tobacco control program consisting of nine components: community programs, chronic disease programs, school programs, enforcement, statewide programs, counter-marketing, cessation programs, surveillance and evaluation, and administration and management.

How much money does the Centers for Disease Control and Prevention recommend for tobacco control in New Hampshire?

In Best Practices for Comprehensive Tobacco Control Programs, the Centers for Disease Control and Prevention provides an upper and lower funding level for tobacco control efforts in each state. Based on data published in 1999, the Centers for Disease Control and

Prevention recommends a lower annual funding level for New Hampshire of $10.9 million and an upper annual funding level of $24.8 million. These estimates are derived from costs in other states that have used a comprehensive approach and been successful in controlling tobacco use.

Where can I obtain information about how to quit smoking?

The NH Tobacco Prevention and Control Program can provide a list of resources within New Hampshire. This program can be reached at 1-800-852-3345, extension 6891. Information may also be found at: http://www.dhhs.nh.gov/DHHS/TPCP/default.htm

2002 NH ATS Results

1. Tobacco Use

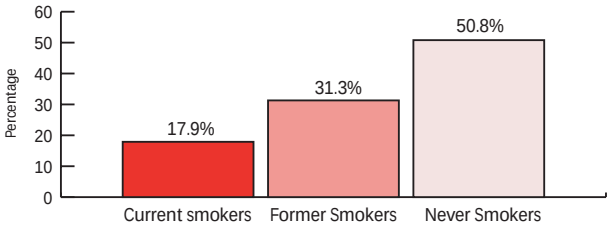
Tobacco use is the leading preventable cause of disease and premature death in New Hampshire and the United States. In New Hampshire, approximately 1,700 people die each year from tobacco related illness. In 1999, 40% of this smoking-attributable mortality was from cancer, 31% was from cardiovascular disease and 29% was from respiratory disease. The economic costs of smoking to individuals and society are high. The smoking attributable medical cost in New Hampshire was estimated to be $440 million annually [2].

Smoking Status

The majority of New Hampshire adults do not smoke. The 2002 NH ATS found that 17.9% of adults were current smokers.

Historically, New Hampshire's adult smoking prevalence has been measured by the Behavioral Risk Factor Surveillance Survey (BRFSS). The BRFSS has been, and is still considered, the "gold standard" for assessing smoking prevalence among New Hampshire adults. The smoking prevalence found in the NH ATS cannot be compared to that found by the BRFSS and does not represent evidence of a change in adult smoking rates. The surveys differ in the timeframe in which they were administered, introductory language and the placement of questions.

Figure 1-1. Smoking status of New Hampshire adults, 2002 NH ATS.



Smoking Status	N	%	95% CI
Current Smokers	525	17.9	16.3-19.5
Former Smokers	987	31.3	29.5-33.1
Never Smokers	1,475	50.8	48.8-52.8

Table 1-1 presents the percentage of current smokers within the New Hampshire population by gender, age, income, education and marital status. Certain subpopulations had a higher proportion of smokers than the statewide average.

- 31.0% (95% CI: 23.3-38.7) of 18-24 year olds smoked in 2002.
- 29.7% (95% CI: 25.1-34.2) of individuals with annual household income between $20,000–34,999 reported current smoking.
- 37.6 % (95% CI: 28.9-46.2) of individuals with less than a high school education smoked.
- 26.1% (95% CI: 23.0-29.2) of unmarried individuals reported smoking.
- The 2002 NH ATS did not detect any statistically significant differences between smoking rates in men and women.

Table 1-1. Smoking prevalence by gender, age, income, education and marital status, 2002 NH ATS.

	N	%	95% CI
Gender			
Male	232	17.9	15.5-20.3
Female	293	17.9	15.8-20.0
Age			
18-24	53	31.0	23.3-38.7
25-34	101	20.2	16.4-24.0
35-44	133	18.2	15.2-21.2
45-54	116	18.3	14.9-21.6
55-64	70	15.0	11.4-18.7
65+	49	9.3	6.5-12.1
Income			
Less than $20,000	67	22.4	16.6-28.2
$20,000-$34,999	143	29.7	25.1-34.2
$35,000-$49,999	96	20.9	16.7-25.1
$50,000 and higher	166	14.0	11.7-16.2
Education			
Less than high school graduate	56	37.6	28.9-46.2
High school diploma or GED	206	25.6	22.1-29.0
Some college or technical school	155	20.1	16.9-23.3
College graduate	105	7.8	6.2-9.4
Marital status			
Married	225	13.2	11.5-14.9
Not married	295	26.1	23.0-29.3

Cigarette Consumption

Not all current smokers smoked everyday and those who only smoked occasionally consumed fewer cigarettes on the days they did smoke.

- On the average, current smokers consumed 16.4 cigarettes per day.
- Everyday smokers made up 82% of current smokers
  - Smokers who smoked everyday consumed an average of 19.1 cigarettes per day.
- Occasional smokers made up 17.7% of current smokers
  - Smokers who smoked only occasionally consumed an average of 6.5 cigarettes per day and smoked, on average 13.9 days per month.

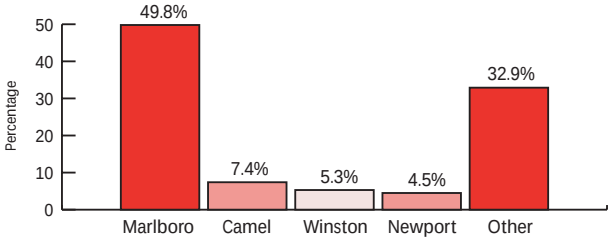
Table 1-2 presents the average number of cigarettes consumed, the average number of days on which cigarettes were smoked in the previous month for everyday and occasional current smokers, and the percentage of current smokers who are everyday versus occasional smokers.

Table 1-2. Smoking frequency and number of cigarettes consumed, current smokers

Status	N	% of current smokers	Average days smoking per month	Average cigarettes smoked per day
Every day smokers	423	82.3%	30	19.1
Some day smokers	102	17.7%	13.9	6.5
All current smokers	525	100.0%	27.2	16.4

Most current smokers (54.0%, 95%: 49.0-59.0) smoked their first cigarette within 30 minutes of waking each morning. Figure 1-2 shows the most common brands of cigarettes smoked by current smokers. About half of current smokers reported that they smoke Marlboro.

Figure 1-2. Brands smoked by current smokers, 2002 NH AT



Brand	N	%	95%CI
Marlboro	237	49.8	44.9-54.8
Camel	32	7.4	4.7-10.2
Winston	25	5.3	2.8-7.8
Newport	22	4.5	2.5-6.5
Other	197	32.9	28.5-37.4

As the health hazards of smoking have been documented, the production of lower tar or "light" cigarettes has increased. Low tar cigarettes do not eliminate the risks associated with smoking. In fact, the risk of lung cancer is only slightly lower when smoking low tar as compared to high-tar cigarettes, and reduced tar levels appear to have no effect on the occurrence of other tobacco related lung or heart diseases. Additionally, some evidence has shown that smokers compensate when smoking low tar products by inhaling more deeply and by smoking more cigarettes [3].

Table 1-2. Characteristics of cigarettes smoked by current smokers, 2002 NH ATS

	N	%	95% CI
Type			
Menthol	94	16.6	13.1-20.0
Plain	429	83.4	80.0-86.9
Price			
Discount	102	17.1	13.6-20.6
Full priced	401	82.9	79.4-86.4
Strength			
Regular	214	43.5	38.6-48.5
Lights	216	41.6	36.8-46.5
Ultra lights	89	14.8	11.7-18.0

2. Cessation

Addiction counselors have compared the addiction to nicotine (a chemical found in tobacco) to the dependence caused by opiates [4]. Quitting is not easy, and often the user experiences many unsuccessful attempts before quitting permanently. Nevertheless even those who quit after the age of 65 years will benefit from cessation by reducing the risk of tobacco-related diseases [5].

Quit Attempts

Within the past year, 55.1% (95%CI: 50.2-59.9) of adult current smokers had stopped smoking for one day or longer in an attempt to quit. Among adults who have been smokers at some time in their lives, 2.1% (95%CI: 1.2-3.0) quit smoking in the previous three months and 4.7% (95%CI: 3.3-6.1) quit in the previous three to twelve months.

About 87.2% (95%CI: 83.7-90.6) of current smokers expect to quit smoking in the future and 79.0% (95%CI: 75.0-83.0) of current smokers believe their attempts to quit would be successful. 58.7% (95%CI: 53.7-63.7) of current smokers are seriously considering quitting within the next six months, and 19.8% (95% CI 16.0%-23.7%): plan to stop smoking within the next thirty days.

Table 2-1 presents the percentage of adult current smokers who have tried to quit in the past year by demographic characteristics.

Table 2-2. Quit attempt in the last twelve months by current smokers, by gender, age, income, education, and marital status, 2002 NH ATS

	N	%	95% CI
Gender			
Male	107	47.0	39.5-54.4
Female	174	62.7	56.5-68.9
Age			
18-24	31	59.8	45.3-74.3
25-34	66	65.7	55.7-75.6
35-44	72	55.7	46.6-64.9
45-54	54	45.8	35.8-55.9
55-64	36	52.8	39.6-66.0
65+	21	44.4	28.9-59.9
Income			
Less than $20,000	36	55.5	41.2-69.8
$20,000-$34,999	79	55.9	46.7-65.0
$35,000-$49,999	45	45.6	34.5-56.8
$50,000 and higher	94	57.1	48.5-65.8
Education			
Less than high school graduate	30	52.1	37.1-67.1
High school diploma or GED	103	49.8	41.9-57.7
Some college or technical school	95	64.4	55.9-72.9
College graduate	53	55.9	45.4-66.4
Marital status			
Married	132	56.4	49.5-63.2
Not married	148	54.6	47.6-61.6
Current smoker			
Everyday smoker	206	50.8	45.3-56.3
Someday smoker	75	75.3	65.9-84.6
Total	**281**	**55.1**	**50.2-59.9**

Assistance With Quitting

The NH ATS measured awareness and the use of counseling and/or pharmacotherapy for smoking cessation by adult smokers. Approximately 78.2% (95%CI: 76.1-83.6) of current smokers are aware of assistance available to them to quit smoking, such as telephone quit lines or local health clinic services.

About 47.7% (95%CI: 40.9-54.6) of current smokers who tried to quit in the previous year used medication such as the nicotine patch or nicotine gum the last time they tried to quit and 7.7% (95%CI: 4.5-10.9) used assistance such as classes or counseling.

Among former smokers who quit during the past 5 years, 25.4% (95%CI: 19.3-31.5) used medication and 3.8% (95%CI: 1.0-6.7) used some other assistance when they quit.

Physician and Health Professional Advice

The combination of pharmacotherapy and counseling achieve the highest rates of smoking cessation [5]. The Public Health Service recently published a clinical practice guideline, *Treating Tobacco Use and Dependence* [4]. The guideline recommends that health care professionals use the "five A's" to help their patients quit smoking: 1) ask about smoking, 2) advise all smokers to quit, 3) address willingness to make a quit attempt, 4) assist patients who want to quit, 5) arrange follow-up visits.

Among all respondents who had seen a health care provider in the previous 12 months, 69.9% (95%CI: 67.8-71.9) were either asked if they smoked cigarettes or advised to quit smoking. Of current smokers who had seen a provider in the previous year, 73.6% (95%CI: 68.5-78.7) said that their doctor, nurse, or other health professional had advised them not to smoke.

Among all respondents who had seen a dentist in the previous 12 months, 36.9% (95%CI: 34.6-39.2) were either asked if they smoked or advised to quit. Of current smokers who had seen a dentist, 38.8% (95%CI: 32.6-44.9) had been advised to quit.

Table 2-3. Cessation methods* offered to current smokers by medical providers, 2002 NH ATS

	N	%	95% CI
Prescribe or recommend a patch, nicotine gum, nasal spray, an inhaler, or pills	120	40.1	33.9-46.3
Suggest setting a specific date to stop smoking	97	31.7	25.9-37.6
Provide booklets, videos, or other materials	78	25.4	19.9-30.9
Suggest using a smoking cessation class, program, quit line, or counseling	61	20.1	15.1-25.3

*Respondents could list one or more methods suggested by their providers.

Worksite Cessation Programs

The NH ATS, found that 18% (95% CI: 16.2-19.8) of all respondents who were employed worked at sites that offered a cessation program. Respondents employed at worksites with policies that banned smoking were more likely to have access to a cessation program at work (24.5% (95% CI: 21.7-27.2) than those whose workplaces allowed smoking (13% (95% CI: 9.2-16.8). Current smokers were less likely than former or never smokers to have cessation assistance available at work. Table 2-4 presents the prevalence of workplace cessation assistance by smoking status.

Table 2-4. Worksite cessation assistance by smoking status, 2002 NH ATS

Smoking status	N	%	95% CI
Current smoker	50	11.8	8.4-15.2
Former smoker	125	19.9	16.5-23.3
Never smoker	218	19.4	16.8-22.0
Total	**393**	**18.0**	**16.2-19.8**

3. Secondhand Smoke

Secondhand smoke, or environmental tobacco smoke, is defined as smoke exhaled by smokers as well as smoke escaping from burning tobacco products. Exposure to secondhand smoke has been linked to a number of adverse health outcomes. These events are preventable by eliminating exposure to secondhand smoke [7]. This is particularly important for children since secondhand smoke increases their risk for lower respiratory tract infection, middle ear infection, asthma episodes and sudden infant death syndrome (SIDS) [8].

Exposure to secondhand smoke was ascertained by asking respondents the number of days anyone had smoked cigarettes, cigars, or pipes anywhere inside their home or car during the past seven days. Table 3-1 and Table 3-2 present the prevalence of exposure to secondhand smoke during the past seven days inside respondents' homes and cars.

Table 3-1. Secondhand smoke exposure in home, by smoking status, 2002 NH ATS

	Exposure to secondhand smoke in home		
	N	**%**	**95% CI**
Current smokers	325	58.2	53.3-63.1
Former smokers	83	9.0	6.9-11.1
Never smokers	78	6.3	4.8-7.9
Total	**486**	**16.4**	**14.9-18.0**

Table 3-2. Secondhand smoke exposure in a car, by smoking status, 2002 NH ATS

	Exposure to secondhand smoke in a car		
	N	**%**	**95% CI**
Current smokers	331	68.0	63.7-72.3
Former smokers	123	14.3	11.6-17.0
Never smokers	134	11.1	9.1-13.1
Total	**589**	**22.2**	**20.5-24.0**

Home and Automobile Smoking Rules

Respondents were asked about the rules regarding smoking inside their homes and automobiles. The majority of respondents do not allow smoking anywhere inside their homes (76%) and cars (71%). Table 3-3 presents smoking rules inside of the house by smoking status.

Table 3-3. Smoking rules inside of the house, by smoking status, 2002 NH ATS

	Smoking not allowed anywhere in home			Smoking not allowed in car		
	N	**%**	**95% CI**	**N**	**%**	**95% CI**
Current smokers	185	40.4	35.5-45.3	110	19.6	15.9-23.3
Former smokers	781	79.4	76.5-82.2	774	77.8	74.7-80.8
Never smokers	1,264	86.0	83.9-88.1	1258	85.3	83.2-87.4
Total	**2,239**	**75.7**	**74.0-77.4**	**2152**	**71.1**	**69.3-73.0**

Workplace Policy and Exposure

The New Hampshire Indoor Smoking Act, which went into effect in 1994, restricts smoking in most public places. In addition to protecting nonsmokers from the risks of secondhand smoke, smoke-free environments have been shown to decrease daily tobacco consumption and to increase smoking cessation among smokers [6]. Among the objectives of *Healthy New Hampshire 2010* is to increase the percentage of employed adults who report a smoke-free work place from 68% to 90%[9].

The ATS asked respondents who worked indoors most of the time about secondhand smoke exposure and workplace smoking policies. For the 2002 NH ATS, a smoke-free workplace was defined as one where the official policy prohibits smoking in both work areas and public areas.

76.7% (95%CI: 74.2-79.1) of respondents reported being employed in a smoke-free workplace. 10.9% (95%CI: 9.0-12.7) of respondents reported that someone had smoked in their work area in the past seven days.

Table 3-4 shows attitudes toward workplace smoking policies among those working at places with smoke-free policies. Table 3-5 presents these attitudes by smoking status. Figure 3-1 presents opinions about workplace smoking and Figure 3-2

Table 3-4. Attitudes toward workplace smoking policies among respondents working at places with a smoke-free policy

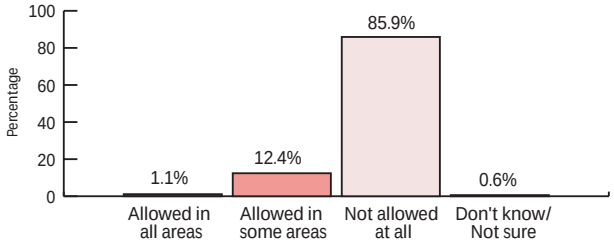
	Respondents working in a smoke-free workplace		
	N	**%**	**95% CI**
Prefer stronger policy	174	14.2	12.1-16.3
Prefer weaker policy	23	1.8	1.0-2.6
Prefer no change in policy	1036	84.0	81.7-86.3
No opinion	10	0.9	0.3-1.5
Total	**1233**	**76.7**	**74.2-79.1**

Table 3-5. Attitudes toward smoking policy among those whose workplaces have smoke-free policies, by smoking status

	Respondents having smoke-free workplace policies								
	Prefer no change			**Prefer weaker policy**			**Prefer stronger policy**		
Smoking status	N	%	95% CI	N	%	95% CI	N	%	95% CI
Current smokers	153	82.3	76.2-88.4	17	9.4	4.7-14.1	15	8.3	4.0-12.6
Non-smokers	878	84.2	81.8-86.6	6	0.5	0-0.9	159	15.3	12.9-17.7

Figure 3-1 presents the opinions regarding workplace smoking of respondents who were employed in work that took place indoors most of the time. Table 3-5 presents these opinions bysmoking status.

Figure 3-1. Percentage of respondents who think smoking should be allowed in all work areas, some areas, or not allowed at all, 2002 NH ATS.



	N	%	95% CI
Allowed in all areas	19	1.1	0.6-1.7
Allowed in some areas	193	12.4	10.5-14.2
Not allowed at all	1,385	85.9	84.0-87.9
Don't know/Not sure	10	0.6	0.2-0.94

Table 3-5. Opinions about workplace smoking, by smoking status, 2002 NH ATS

	Allowed in all or some areas			Not allowed at all		
Smoking status	N	%	95%CI	N	%	95% CI
Current smoker	92	35.9	29.4-42.4	182	64.1	57.6-70.6
Former smoker	65	14.0	10.5-17.4	400	86.0	82.6-89.5
Never smoker	55	6.4	4.5-8.3.	798	93.6	91.7-95.5

Attitudes About Clean Indoor Air

Smoking is permitted in many New Hampshire restaurants. There, secondhand smoke affects both non-smoking patrons and restaurant workers. Studies have shown that restaurant employees have an increased rate of lung cancer and heart disease as a result of exposure to secondhand smoke in the workplace [10,11]. In 2001, the New Hampshire Department of Health and Human Services surveyed restaurants about their current smoking policies and found that 56.5% of New Hampshire restaurants do not allow smoking [2]. New Hampshire's Indoor Smoking Act (RSA 155:64-77) regulates smoking in enclosed workplaces and enclosed places accessible to the public, regardless of whether they are publicly or privately owned, and in enclosed publicly owned buildings and offices. In restaurants, smoking is permitted if smoking areas are effectively segregated from non-smoking areas, and in restaurants with seating for fewer than 50 people.

The 2002 NH ATS asked respondents about their smoking/non-smoking dining preferences. 17.1% (95%CI: 15.7-18.6) of respondents reported not going to a restaurant in the past year because they knew that smoking was permitted. Alternatively, 7.2% (95%CI: 6.1-8.2) of respondents reported not going to a restaurant because they knew that smoking was not permitted. 56.4% (95%CI: 54.4-58.4) of respondents said they would ask people to stop smoking in the nonsmoking area of a restaurant. During the previous 12 months, 19.1% (95%CI: 17.4-20.7) of respondents had asked a stranger not to smoke around them in order

to avoid exposure to secondhand smoke. Respondents were also asked if they would support a law that would make all restaurants smoke-free in their community, and if such a law was enacted, would they eat out more often, less often, or the same amount. 69.7% (95%CI: 67.8-71.5) of respondents would support such a law. If such a law was enacted, 9.2% (95%CI: 8.1-10.3) of respondents said they would eat out more often, 4.9% (95%CI: 4.0-5.8) would eat out less often, and 85.9% (95%CI: 84.5-87.3) would not change their eating patterns. Tables 3-6 through 3-10 below present respondents' attitudes toward clean indoor air in restaurants and other public places.

Table 3-6. Attitudes regarding clean indoor air rules, indoor dining areas, 2002 NH ATS

Smoking should be:	N	%	95% CI
Allowed in all areas	38	1.2	0.7-1.6
Allowed in some areas	1,111	37.7	35.8-39.7
Not allowed at all	1,797	59.3	57.3-61.3
No opinion	54	1.8	1.3-2.3

Table 3-7. Attitudes regarding clean indoor air rules, shopping malls, 2002 NH ATS

Smoking should be:	N	%	95% CI
Allowed in all areas	47	1.5	1.0-2.0
Allowed in some areas	703	22.3	21.0-24.3
Not allowed at all	2,203	74.2	72.5-76.0
No opinion	46	1.6	1.1-2.2

Table 3-8. Attitudes regarding clean indoor air rules, public buildings, 2002 NH ATS

Smoking should be:	N	%	95% CI
Allowed in all areas	37	1.2	0.8-1.6
Allowed in some areas	679	22.4	20.7-24.0
Not allowed at all	2,242	74.8	73.0-76.5
No opinion	42	1.7	11.2.3

Table 3-9. Attitudes regarding clean indoor air rules, indoor sporting events and concerts, 2002 NH ATS

Smoking should be:	N	%	95% CI
Allowed in all areas	65	2.6	1.9-3.3
Allowed in some areas	538	18.9	17.2-20.5
Not allowed at all	2,345	76.8	75.0-78.5
No opinion	52	1.8	1.3-2.4

Table 3-10. Attitudes regarding clean indoor air rules, bars, 2002 NH ATS.

Smoking should be:	N	%	95% CI
Allowed in all areas	456	16.1	14.6-17.7
Allowed in some areas	1,402	48.3	46.3-50.3
Not allowed at all	980	30.5	28.7-32.3
No opinion	160	5.1	4.3-6.0

4. Risk Perception and Social Acceptability

One of the methods by which the NH Tobacco Prevention and Control Program accomplishes its goals is though educating NH residents about the dangers of tobacco use and secondhand smoke exposure. Through the NH ATS, the Tobacco Prevention and Control Program can document progress it has made in this area, and assess further educational needs. Changes in knowledge and attitudes are often the first step to reach the goal of reducing death and disease from tobacco.

Risk Perception

Scientific evidence has shown that smokers have increased risk for cancer of the lung, mouth, esophagus and larynx, and also are at greater risk for heart disease, stroke and emphysema [12]. The ATS measured respondents' knowledge regarding risks involved in tobacco use by reading several statements and asking respondents if they strongly agreed, agreed, disagreed, or strongly disagreed with the statement. The tables and figures below present respondents perception of the risks of tobacco use.

Respondents to the 2002 ATS were asked about their perceptions of the benefit of quitting smoking after 20 years. Although the majority of NH residents understood that there are health benefits to quitting even after smoking for a long period, current smokers were significantly less likely than former or never smokers to believe in the benefits of quitting after long-term smoking.

Table 4-1. Disagree or strongly disagree that there is little health benefit to quitting after smoking for 20 years, 2002 NH ATS

	N	%	95% CI
Current smoker	390	74.6	70.0-79.2
Former smoker	804	84.6	82.0-87.2
Never smoker	1,178	81.7	79.4-84.0
Total	**1,894**	**81.3**	**79.6-83.0**

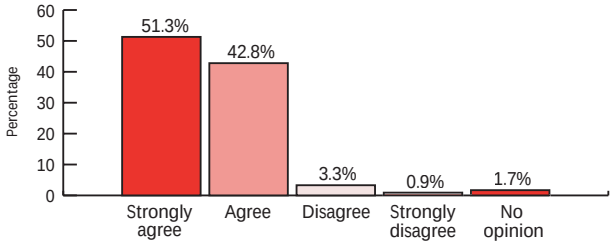
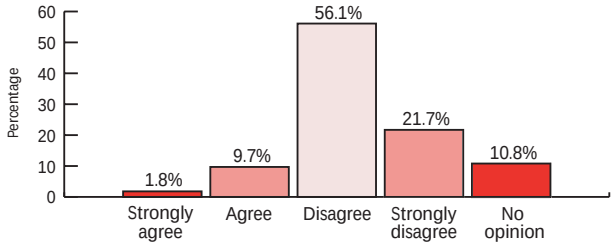


Figure 4-1. Perceived risk of addiction, 2002 NH AT

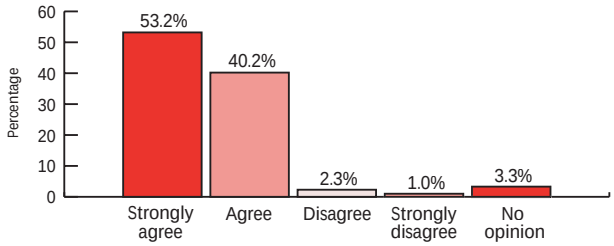
	N	%	95% CI
Strongly agree	1,546	51.3	49.3-53.3
Agree	1,274	42.8	40.8-44.8
Disagree	93	3.3	2.53-4.05
Strongly disagree	26	0.9	0.5-1.2
No opinion	59	1.7	1.3-2.2

Figure 4-2. Perceived risk of light cigarettes



	N	%	95% CI
Strongly agree	55	1.8	1.2-2.4
Agree	290	9.7	8.5-10.9
Disagree	1,668	56.1	54.1-58.1
Strongly disagree	643	21.7	20.0-23.3
No opinion	340	10.8	9.6-12.0

Figure 4-3. Perceived risk to fetus during pregnancy



	N	%	95% CI
Strongly agree	1,572	53.2	51.2-55.2
Agree	1,202	40.2	38.3-42.3
Disagree	77	2.3	1.7-2.9
Strongly disagree	28	1.0	0.6-1.4
No opinion	115	3.3	2.6-3.9

Since 1981, when Takeshi Hirayama's study provided the first conclusive evidence on the dangers of passive smoking, research has broadened and new scientific evidence has accumulated [13]. It is believed that each year, secondhand smoke causes as many as 3,000 lung cancer deaths and up to 62,000 deaths from coronary heart disease in the United States [7].

Respondents were asked about their knowledge of the dangers of breathing secondhand smoke. Most, 57.5% (95%CI: 55.5-59.5) thought breathing secondhand smoke was very harmful to one's health. Table 4-1 shows respondents' knowledge about the dangers of secondhand smoke. Table 4-2 presents respondents knowledge of the dangers of specific diseases and conditions caused by secondhand smoke and Table 4-3 presents respondents' knowledge by smoking status.

Table 4-2. Knowledge of the dangers of secondhand smoke, 2002 NH ATS

Secondhand smoke is:	N	%	95% CI
Very harmful	1,723	57.5	55.5-59.5
Somewhat harmful	1,011	34.0	32.1-35.9
Not very harmful	115	4.0	3.2-4.8
Not harmful at all	63	1.8	1.3-2.3
No opinion	83	2.7	2.1-3.4

Table 4-3. Percentage of respondents who think breathing other people's cigarette smoke causes specific diseases and conditions, 2002 NH ATS

Condition	N	%	95% CI
Lung cancer	2,507	93.1	92.0-94.1
Heart disease	2,171	89.6	88.3-91.0
Respiratory problems in children	2,703	97.0	96.3-97.7
SIDS	770	62.1	59.1-65.0

Table 4-4. Percentage of current smokers, former smokers and never smokers who think breathing other peoples' cigarette smoke causes selected diseases and conditions, 2002 NH ATS

	Current smokers			Former smokers			Never smokers		
	N	%	95% CI	N	%	95% CI	N	%	95% CI
Lung cancer	382	82.9	79.1-86.7	804	92.0	90.1-93.9	1,312	97.2	96.3-98.1
Heart disease	338	80.0	75.7-84.2	728	90.0	87.8-92.1	1,097	93.0	91.4-94.7
Respiratory problems in children	434	92.5	89.9-95.0	879	96.7	95.5-97.9	1,384	98.7	98.0-99.3
SIDS	115	47.1	40.2-54.0	214	57.7	52.3-63.0	439	70.4	66.5-74.2

Respondents were asked, how they thought their health was, in general. Current smokers were significantly less likely to report very good or excellent health than former or never smokers. Table 4-4 shows perceived health of current smokers, former smokers and never smokers.

Table 4-5. Perception of heath, by smoking status, NH ATS, 2002

	Perception of health - excellent/very good		
	N	%	95% CI
Never smokers	1,052	73.7	71.2-76.2
Former smokers	595	61.6	58.2-65.0
Current smokers	260	47.1	42.2-52.0

Social Acceptability

88.6% (95%CI: 87.3-89.9) of respondents support efforts to encourage people not to smoke and 71.5% (95%CI: 69.7-73.3) of respondents have encouraged someone they know not to start or to stop using tobacco products during the past twelve months. 23.3% (95%CI: 21.5-25.0) of respondents believe that it is acceptable for an adult to smoke when they are around an adult non-smoker, 5.7% (95%CI: 4.7-6.7) believe it is acceptable to smoke around children and 4.5% (95%CI: 3.6-5.3) believe it is acceptable for a woman to smoke when she is pregnant.

New Hampshire residents overestimated the number of smokers in the state. Respondents thought an average of 49.0% of high school students and 49.0% of adults smoked. In reality, the 2002 NH ATS found that 17.9% of adults smoke. In the 2001 NH YTS, 25% of high school students smoked.

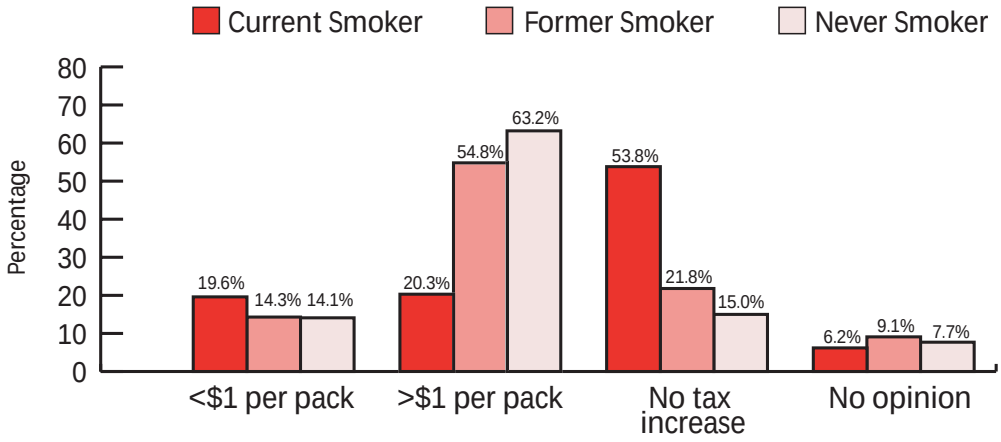
5. Policy Issues

In the United States, the federal, state, and some local governments tax tobacco. Studies on cigarette demand have demonstrated that an increase in cigarette price leads to substantial reductions in cigarette smoking by deterring smoking initiation among youth, prompting smoking cessation among adults, and reducing the average cigarette consumption among continuing smokers. The 1989 Surgeon General's report projected that a 10% increase in cigarette price would result in an overall decrease of 4.7% in the number of cigarettes consumed [14].

Taxation

68.0% (95%CI: 66.9-70.7) of ATS respondents supported an additional tax on a pack of cigarettes if some or all of the money raised would be used to fund tobacco prevention programs. The Figure below depicts the respondents' opinions overall and by smoking status.

Figure 5-1. Amount of additional cigarette tax supported by NH residents, 2002 NH ATS.



	Current smoker			Former smoker			Never smoker		
	N	%	95%CI	N	%	95% CI	N	%	95% CI
< $1 per pack	103	19.6	15.9-23.4	142	14.3	11.9-16.7	209	14.1	12.1-16.1
> $1 per pack	103	20.3	16.3-24.4	528	54.8	51.4-58.3	938	63.2	60.4-66.0
No tax increase	285	53.8	48.9-58.7	221	21.8	18.9-24.6	211	15.0	12.9-17.1
No opinion	33	6.2	3.9-8.5	90	9.1	7.1-11.0	113	7.7	6.1-9.2

6. Parental Involvement

Parents have a major influence in their childrenís lives. The Centers for Disease Control recommend beginning the dialog about tobacco use at age five or six and continuing through the high school years. Parents are encouraged to talk to their children about tobacco and discuss the media portrayal of tobacco products [15]. Based on data from the 2001 NH Youth Tobacco Survey (NH YTS), 7.4% of middle school students and 30.7% of high school students were current users of tobacco products (including cigarettes, cigars, smokeless tobacco, pipes, and bidis).

Parent-Child Communication

Respondents were asked how often had they talked to their child about tobacco during the past six months. 77.1% of parents and/or stepparents had talked to their child (aged 5-17), and 64.5% had advised their child against tobacco use.

Table 6-1. Parent-child communication about tobacco, 2002 NH ATS

Talked to child about tobacco:	N	%	95% CI
Never	188	22.9	19.8-26.0
Once	79	9.9	7.6-12.2
Twice	118	14.9	12.2-17.7
Three or more times	482	52.3	48.6-55.9

Table 6-2. Parent-child communication about tobacco, 2002 NH ATS

Advised child against tobacco use:	N	%	95% CI
Never	293	35.5	31.9-39.0
Once	78	10.0	7.7-12.4
Twice	84	10.0	7.7-12.2
Three or more times	399	44.6	40.9-48.2

Never smokers and current smokers were more likely than former smokers to live with one or more children under 18 years of age. This may be a result of the older mean age of former smokers compared to other respondents. Former smokers had an average age of 52 years (95% CI: 50.9-53.3) compared to current smokers (40 years, 95% CI: 38.9-42.0) and never smokers (43 years, 95% CI: 42.3-44.2). Table 6-3 shows the percentage of respondents who lived with one or more children under 18 years of age by smoking status.

Table 6-3. Percent of respondents with children in the home by smoking status

Smoking status	N	%	95% CI
Current smoker	210	44.4	42.5-49.3
Former smoker	276	31.5	28.2-34.8
Never smoked	623	45.5	42.6-48.3
Total	**1,113**	**40.9**	**38.9-42.9**

7. Media

In 2001, the tobacco industry spent approximately $42.5 million marketing tobacco products in New Hampshire [19]. The NH Tobacco Prevention and Control Program has attempted to counter tobacco marketing by engaging in a statewide counter-marketing effort that includes placement of printed material and broadcast of tobacco prevention advertisements. Counter-marketing activities can promote quitting and decrease the likelihood of children and young people beginning to use tobacco [6]. Other states have shown that media messages influence public support for tobacco control policy and establish a supportive climate for school and community prevention efforts [6].

Counter-marketing Exposure

Respondents were asked, on average, how many hours a week they watch television, listen to the radio or surf the internet. Reported frequencies for media exposure during preceding seven days are shown in Table 7-1. Current smokers spend significantly more hours watching television than never smokers and significantly more time listening to the radio than former or never smokers. There are no significant differences by smoking status in time spent surfing the internet.

Table 7-1. Average hours of media exposure

	Television			Radio			Internet		
	N	Mean	95% CI	N	Mean	95% CI	N	Mean	95% CI
Current smoker	519	34.3	30.9-37.7	520	42.9	38.5-47.3	524	13.0	10.6-15.4
Former smoker	969	32.1	29.9-34.3	972	30.2	27.4-33.0	976	12.2	10.6-13.8
Never smoker	1,453	27.1	25.6-26.6	1,454	31.8	29.2-34.4	1,454	15.2	13.4-17.0
Total	**2,954**	**29.9**	**28.7-31.1**	**2,959**	**33.3**	**31.5-35.1**	**2,967**	**13.8**	**12.7-14.9**

When asked about the number of anti-smoking advertisements they had seen in the previous week, 52.2% of adults reported they had seen one or more anti-smoking television commercials, 32.8% had heard anti-smoking radio advertisements and 33.8% had been exposed to advertisements on billboards, posters or other print materials.

Table 7-2. Media exposure to anti-smoking advertisements, 2002 NH ATS

	Television			Radio			Billboards		
	N	%	95%CI	N	%	95%CI	N	%	95%CI
None	1,275	47.8	45.6-50.0	1,669	67.2	65.0-69.4	1,918	66.2	64.2-68.2
One	262	10.6	9.3-11.9	183	7.6	6.4-8.8	256	9.5	8.3-10.8
Two or three	533	22.2	20.3-24.1	285	12.9	11.4-14.5	385	15.2	13.6-16.7
Four to six	222	9.3	8.0-10.6	126	6.0	4.8-7.1	142	5.3	4.3-6.3
Seven or more	247	10.2	8.8-11.5	127	6.3	5.1-7.6	95	3.8	3.0-4.7

References

[1] American Cancer Society. Cancer facts and figures 2003. Atlanta (GA): American Cancer Society; 2003.

[2] Ramsey L. New Hampshire Tobacco Data 2002. New Hampshire Department of Health and Human Services, Office of Community and Public Health, Division of Chronic Disease Prevention, Tobacco Prevention and Control Program, 2002.

[3] National Cancer Institute. Risks Associated with Smoking Cigarettes with Low Machine-Measured Yields Of Tar And Nicotine. Smoking and Tobacco Control Monograph No. 13. Bethesda, MD: U.S. Department of Health and Human Services, National Institutes of Health, National Cancer Institute, NIH Pub. No. 02-5074, October 2001.

[4] Fiore M., Bailey W., Cohen S. Treating Tobacco Use and Dependence: a Systems Approach. Clinical Practice Guideline. Rockville, MD: US Department of Health and Human Services, Public Health Service, June 2000.

[5] Rigotti N. Treatment of tobacco use and dependency. New England Journal of Medicine, Vol. 346, No.7, February 14, 2002.

[6] U.S. Department of Health and Human Services. Reducing tobacco use: a report of the surgeon general. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2000. Reprinted, with corrections, October 2000.

[7] National Cancer Institute. Health effects of exposure to environmental tobacco smoke: the report of the California Environmental Protection Agency. Smoking and tobacco control monograph No.10. Bethesda, MD. U.S. Department of Health and Human Services, National Institutes of Health, National Cancer Institute, NIH Pub. No. 99-4645, 1999.

[8] California Office of Environmental Health Hazard Assessment. Heath effects. Available at http://www.oehha.org/air/environmental_tobacco/finalets.html Accessed 4/28/03.

[9] Healthy New Hampshire 2010. New Hampshire Department of Health and Human Services, March 2001.

[10] Siegel M. Smoking and restaurants: a guide for policy makers. University of California, Berkeley –University of California, San Francisco; American Heart Association California Affiliate, Alameda County Health Care Services Agency, Tobacco Control Program, September 1992.

[11] Siegel M. Smoking and bars: a guide for policy makers. Boston, MA: Boston University School of Public Health, January 1998.

[12] Mackay J., Eriksen M. The tobacco atlas. World Health Organization, 2002.

[13] Hirayama T. Non-smoking wives of heavy smokers have a higher risk of lung cancer: a study from Japan. British Medical Journal, 1981; 282 (6259): 183-185.

[14] U.S. Department of Health and Human Services. Reducing the Health Consequences of Smoking: 25 Years of Progress: a Report of the Surgeon General. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, DHHS Publication No. (CDC) 89-8411, 1989.

[15] CDC, OSH: Available at: http://www.CDC.gov/tobacco Accessed 5/28/03.

[16] The American Heritage Dictionary of the English Language, 4th edition, Houghton Mifflin Company, 2000.

[17] The American Legacy Foundation: Available at: http://www.americanlegacy.org.

[18] Centers for Disease Control and Prevention. Available at: http://www.cdc.gov/reproductivehealth/ih_sidsmmwr.htm

[19] Campaign For Tobacco Free Kids. Available at : http://www.tobaccofreekids.org/reports/settlements/

Appendix A: Definitions

Bidis: A thin, often flavored Indian cigarette made of tobacco wrapped in a tendu leaf [16]

Confidence Interval: The confidence interval represents the degree of uncertainty associated with each estimate. Because these data were collected from a sample of the population, each percentage is an estimate and has an associated confidence interval or margin of error. For example, Table 1-1 reports that 31.0% of 18-24 year olds smoked in 2002 with a 95% confidence interval of 23.3-38.7. This means that the best estimate of 18-24 year old smokers is 31% but that we are confident that the true value will be found in the interval 23.3% to 38.7% 95% of the time.

Counter-Marketing: Counter Marketing is advertising and public information that attempts to counter pro-tobacco messages and increase pro-health messages and influences.

Current Smoker: A respondent who has smoked 100 or more cigarettes during their life and who currently smokes on some or all days.

Former Smoker: A respondent who has smoked 100 or more cigarettes during their life and who does not currently smoke on some or all days.

MSA: Master Settlement Agreement. An agreement signed in November 1998 between attorneys general in 46 states and five U.S. territories and the tobacco industry. The agreement resolved lawsuits filed by the attorneys general against the tobacco industry. The agreement provides monetary compensation to states and requires tobacco companies to take down all billboard advertising and advertising in sports arenas, to stop marketing tobacco products to children and to make many of their internal documents available to the public. [17]

Never Smoker: A respondent who has not smoked 100 or more cigarettes during their life.

Nicotine: A colorless, poisonous alkaloid, derived form the tobacco plant. It is a substance in the tobacco to which to which smokers may become addicted. [16]

Secondhand Smoke: Smoke from burning tobacco products including that exhaled by smokers and that escaping directly from the burning tobacco. Also called passive smoking, environmental tobacco smoke (ETS) and side stream smoke.

Smoke-free workplace: For the purposes of the 2002 NH ATS, a respondent working in a smoke-free workplace is employed indoors most of the time; is employed for wages or self-employed and; works at a site where there is an official policy that prohibits smoking in both work areas and public areas.

Smokeless Tobacco: Also called chew or spit tobacco is a tobacco product that is held in the mouth.

Statistical Significance: For the purposes of this report, statistical significance means that 95% confidence intervals do not "overlap" (do not include the same percentages).

Sudden Infant Death Syndrome (SIDS): Sudden Infant Death Syndrome (SIDS) is defined as the sudden death of an infant under one year of age that cannot be explained after a thorough case investigation, including a complete autopsy, examination of the death scene, and review of the clinical history. [18]

Tar: A solid residue of tobacco smoke containing byproducts of combustion [16].

Appendix B: 2002 NH ATS Questionnaire

Section 1: Initial Demographic Items

1. Would you say that in general your health is:

   1. Excellent
   2. Very good
   3. Good
   4. Fair
   5. Poor
   7. Don't know/Not sure
   9. Refused

A.1 What county do you live in?
__ __ __ FIPS county code

   7. Don't know/Not sure
   9. Refused

NH.1 What town do you live in?

__ __ __ Town Code

   7. Don't know/Not sure
   9. Refused

A.3 Do you have any kind of health care coverage, including health insurance, prepaid plans such as HMO's, or government plans such as Medicare?

   1. Yes
   2. No
   7. Don't know/Not sure
   9. Refused

   34. How many children live in your household who are:

   _____ a. Younger than 5 years old
   _____ b. 5 through 11 years old
   _____ c. 12 to 17 years old

Section 2: Tobacco Use

2. Have you smoked at least 100 cigarettes in your entire life?

   1. Yes → Go to Q3
   2. No → Skip to Q14
   7. Don't know/Not sure → Skip to Q14
   9. Refused → Skip to Q14

3. Do you now smoke cigarettes everyday, some days, or not at all?

1. Everyday → Go to Q4
2. Some days→ Go to Q5
3. Not at all → Go to Q8
9. Refused → Skip to Q14

4. On the average, about how many cigarettes a day do you now smoke?

1. Number of cigarettes____ → Go to Q7
77. Don't know/Not sure → Go to Q7
99. Refused → Go to Q7

5. Now I'd like you to think about the past 30 days, that is since [DATE FILL]. On how many of the past 30 days did you smoke cigarettes?

1. Number of Days ___ ___
2. None → Go to Q7
77. DK/Not sure → Go to Q7
99. Refused → Go to Q7

6. On the average, on days when you smoked during the past 30 days, about how many cigarettes did you smoke a day?

1. Number of cigarettes____
77. Don't know/Not sure
99. Refused

7. How soon after you wake up do you have your first cigarette?

1. Within 5 minutes
2. 6-30 minutes
3. 31-60 minutes
4. After 60 minutes
7. Don't know/Not sure
9. Refused

B.7 What brand of cigarettes do you smoke most often?

1. Benson & Hedges
2. Camel
3. Carlton
4. Generic
5. Kent
6. Kool
7. Marlboro
8. Merit
9. More
10. Newport
11. Pall Mall
12. Salem

13. Virginia Slims
14. Winston
15. Lucky Strike
16. Other (specify)
17. Don't know
18. Refused

B.8 What type of cigarettes do you smoke? Are they menthol or plain?

1. Menthol
2. Plain
7. Don't know/Not sure
9. Refused

B.9 Do you smoke discount or full priced cigarettes?

1. Discount or generic
2. Premium or full priced
7. Don't know/Not sure
9. Refused

B.10 Are they regular, lights, or ultra lights?

1. Regular
2. Lights
3. Ultra lights
7. Don't know/Not sure
9. Refused

Ask if FORMER SMOKER [Core Q2 = 1 "yes" and Q3 = "Not at all"]

8. About how long has it been since you last smoked cigarettes regularly?

1. Within the past month (≤ 1 month ago)
2. Within the past 3 months (>1 month but less than 3 months ago)
3. Within the past 6 months (>3 months but less than 6 months ago)
4. Within the past year (>6 months but less than 1 year ago)
5. Within the past 5 years (>1 year but less than 5 years ago

[If Q8 = 1 - 5: Go to Q10]

6. Within the past 10 years (>5 years but less than 10 years ago)
7. 10 or more years ago
8. Don't know/Not sure
9. Refused

[If Q8 = 6 -9: Go to Q14]

Section 3: Cessation

Ask C.1, C.7, C.8, C.9, Q9 of CURRENT SMOKERS [Q3 = 1 “Every day” or 2 “Some days”]

9. During the past 12 months, have you stopped smoking for one day or longer because you were trying to quit smoking?

1. Yes
2. No
7. Don't know/Not sure
9. Refused

C.1 Have you ever stopped smoking for a day or longer because you were trying to quit smoking?

1. Yes
2. No → Go to Q.C.7
7. Don't know/Not sure
9. Refused

C7. Are you aware of assistance that might be available to help you quit smoking, such as telephone Quitlines, or local health clinic services?

1. Yes
2. No
7. Don't know/Not sure
9. Refused

C.8 Have you ever used a nicotine skin patch, gum, inhaler, or nasal spray?

1. Yes → Go to Q10
2. No
7. Don’t know → Go to Q10
9. Refused → Go to Q10

C.9 Why haven't you used a nicotine skin patch, gum, inhaler, or nasal spray?

1. Not safe
2. Cost
3. Doesn't work
4. A nicotine skin patch, gum, inhaler, or nasal spray, is addictive
5. Not available without a prescription
6. Did not try to quit
7. Other: (Record): _____
8. Don’t know/Not sure
9. Refused

Ask Q10, C.5, C.6, Q11 of: CURRENT SMOKERS who made a quit attempt in the past year (Q9 = 1 "yes") or FORMER SMOKERS who quit in last 5 years (Q8 = 1 - 5)

10. When you quit smoking…
The last time you tried to quit smoking…
did you use the nicotine patch, nicotine gum, or any other medication to help you quit?

1. Yes
2. No → Go to Q11
7. Don't know/Not sure
9. Refused

C.5 Did you use?

		YES	NO
1.	A nicotine gum	1	2
2.	A patch	1	2
3.	A nasal spray	1	2
4.	An inhaler	1	2
5.	Zyban or Buproprion	1	2
6.	Wellbutrin	1	2
7.	Other?	1	2

Specify:_____

11. When you quit smoking for good…
The last time you tried to quit smoking…
did you use any other assistance such as classes or counseling?

1. Yes
2. No → Go to Q.C.2
7. Don't know/Not sure
9. Refused

C.6 Did you use?

		YES	NO
1.	A stop smoking clinic or class	1	2
2.	A telephone quit line	1	2
4.	One-on-one counseling from a doctor or nurse	1	2
5.	Self help material, books or videos	1	2
5.	Acupuncture	1	2
6.	Hypnosis	1	2
7.	Other?	1	2

Specify: _____

Ask C.2, C.3, Q12, Q13 of CURRENT SMOKERS [Q3 = 1 “Every day” or 2 “Some days”]

C.2. Do you ever expect to quit smoking?

1. Yes ——→
2. No
7. Don't know/Not sure
9. Refused

C.3 If you decided to give up smoking altogether, how likely do you think you would be to succeed?

1. Very likely
2. Somewhat likely
3. Somewhat unlikely
4. Very unlikely
7. Don't know/Not sure
9. Refused

12. Are you seriously considering stopping smoking within the next six months?

1. Yes
2. No → Go to Q14
7. Don't know/Not sure → Go to Q14
9. Refused → Go to Q14

13. Are you planning to stop smoking within the next 30 days?

1. Yes
2. No
7. Don't know/Not sure
9. Refused

14. During the past 12 months, have you seen a doctor or other health professional to get any kind of care for yourself?

1. Yes
2. No → Go to Q.C.4a
7. Don't know/Not sure → Go to Q.C.4a
9. Refused → Go to Q.C.4a

Ask Q 15 of current smokers [Q3="every day" or "some days"]

15. During the past 12 months, did any doctor, nurse, or other health professional advise you to not smoke?

1. Yes → Go to Q.C.4a
2. No → Go to Q16
6. Don't know → Go to Q.C.4a
9. Refused → Go to Q.C.4a

Ask Q16 of never smokers [Q2=2], of former smokers [Q3=3], and of smokers who were not advised to quit [Q15=2]

16. During the past 12 months, did any doctor, or other health professional ask if you smoke?

1. Yes
2. No
7. Don't know
9. Refused

C.4a During the past 12 months, have you seen a dentist?

1. Yes
2. No → Go to Q17
7. Don't know/Not sure → Go to Q17
9. Refused → Go to Q17

Ask C.4b if current smoker [Q3="every day" or "some days"]

C.4b During the past 12 months, did a dentist advise you to quit smoking?

1. Yes → Go to Q17
2. No → Go to Q.C.4c
7. Don't know/Not sure → Go to Q17
9. Refused → Go to Q17

Ask C.4c if "no" to C4b [C.4b = 2], if non smoker [Q2=2], or former smoker [Q3=3

C.4c During the past 12 months, did a dentist ask if you smoked?

1. Yes → Go to Q.C.11
2. No → Go to Q.C.11
7. Don't know/Not sure → Go to Q.C.11
9. Refused → Go to Q.C.11

Ask Q17 if Q15 =1 or Q.C.4b = 1

17. During the past 12 months, when a doctor, or other health professional advised you to quit smoking, did they also do any of the following?

	YES	NO
1. Prescribe or recommend a patch, nicotine gum, nasal spray, an inhaler or pills such as Zyban?	1	2
2. Suggest that you set a specific date to stop smoking?	1	2
3. Suggest that you use a smoking cessation class, program, quit-line or counseling	1	2
4. Provide you with booklets, videos, or other materials to help you quit smoking on your own?	1	2

Ask C.10 if Q34 a. + Q34B. + 34c. > 0, if Q14 =1, or Q4a = 1]:

C.10 During the past 12 months, did any doctor, or other health professional ask if you smoke around your Children?

1. Yes
2. No
7. Don't know
9. Refused

C.11 Within the past 12 months, has your employer offered any stop smoking program or any other help to employees who want to quit smoking?

1. Yes
2. No
3. Was not employed in past 12 months.
7. Don't know/Not sure
9. Refused

Section 4: Environmental Tobacco Smoke

18. Not including yourself, how many of the adults who live in your household smoke cigarettes, cigars or pipes?

_____ # of adults
00 None
7. Don't know/Not sure
9. Refused

19. During the past 7 days, that is since [DATEFILL}, how many days did anyone smoke cigarettes, cigars, or pipes anywhere inside your home?

1. Less than 1 day per week/rarely/none
2. ___ days (1-7)
7. Don't know/Not sure
9. Refused

20. Which statement best describes the rules about smoking inside your home? Do not include decks, garages, or porches. The BRFSS does not include this last sentence.

1. Smoking is not allowed anywhere inside your home
2. Smoking is allowed in some places or at some times
3. Smoking is allowed anywhere inside the home
7. Don't know/Not sure
9. Refused

RKM 2. Which statement best describes the rules about smoking inside your car, truck or automobile?

1. Smoking is not allowed anytime inside your car
2. Smoking is allowed at some time inside your car
3. Smoking is allowed anytime inside your car
7. Don't know/Not sure
9. Refused

21. Are you currently…

1. Employed for wages
2. Self-employed
3. Out of work for more than 1 year → Go to Q27
4. Out of work for less than 1 year → Go to Q27
5. A homemaker → Go to Q27
6. A Student → Go to Q27

7. Retired, or → Go to Q27
8. Unable to work → Go to Q27
9. Don't know → Go to Q27
10. Refused → Go to Q27

D.1 Do more than 50 people work for you/your employer?

1. Yes
2. No
3. Not applicable
7. Don't know/Not sure
9. Refused

22. While working at your job, are you indoors most of the time?

1. Yes
2. No → Go to Q27
7. Don't know/Not sure → Go to Q27
9. Refused → Go to Q27

23. As far as you know, in the past seven days, that is since [DATE FILL], has anyone smoked in your work area?

1. Yes
2. No
7. Don't know/Not sure
9. Refused

24. Which of the following best describes your place of work's official smoking policy for work areas?

1. Not allowed in any work areas
2. Allowed in some work areas
3. Allowed in all work areas or
4. No official policy
7. Don't know/Not sure
9. Refused

25. Which of the following best describes your place of work's official smoking policy for indoor public or common areas, such as lobbies, rest rooms, and lunchrooms?

1. Not allowed in any public areas
2. Allowed in some public areas
3. Allowed in all public areas
4. No official policy
7. Don't know/Not sure
9. Refused

26. In indoor work areas, do you think smoking should be allowed in all areas, some areas or not at all?

1. Allowed in all areas
2. Allowed in some areas

3. Not allowed at all
7. Don't know/Not sure
9. Refused

D.2 Would you prefer a stronger workplace smoking policy, a weaker workplace smoking policy, or no change [in your current policy]?

1. Prefer stronger policy
2. Prefer weaker policy
3. Prefer no change
7. No opinion/Don't know
9. Refused

27. In the past seven days, that is since [DATE FILL], have you been in a car with someone who was Smoking?

1. Yes
2. No
7. Don't know/Not sure
9. Refused

28. In the indoor dining area of restaurants, do you think that smoking should be allowed in all areas, some areas, or not allowed at all?

1. Allowed in all areas
2. Allowed in some areas
3. Not allowed at all
7. No opinion/Don't know
9. Refused

29. In indoor shopping malls, do you think that smoking should be allowed in all areas, some areas, or not allowed at all?

1. Allowed in all areas
2. Allowed in some areas
3. Not allowed at all
7. No opinion/Don't know
9. Refused

D.3 In public buildings, do you think that smoking should be allowed in all areas, some areas, or not allowed At all?

1. Allowed in all areas
2. Allowed in some areas
3. Not allowed at all
7. No opinion/Don't know
9. Refused

D.4 In bars and cocktail lounges, do you think smoking should be allowed in all areas, some areas or not at all?

1. Allowed in all areas
2. Allowed in some areas
3. Not allowed at all
7. No opinion/Don't know
9. Refused

D.6 In indoor sporting events and concerts, do you think that smoking should be allowed in all areas, some areas, or not allowed at all?

1. Allowed in all areas
2. Allowed in some areas
3. Not allowed at all
7. No opinion/Don't know
9. Refused

D.7 About how often do you eat out at a restaurant a week? Would you say: more than once per week, about once a week, about once or twice a month, less than once a month, or never?

1. More than once per week
2. About once a week
3. About once or twice a month
4. Less than once a month
5. Never
7. Don't know/Not sure
9. Refused

D.8 In the past year, did you not go to a restaurant because you knew smoking was permitted?

1. Yes
2. No
7. Don't know/not sure
9. Refused

D.9 In the past year, did you not go to a restaurant because you knew smoking was not permitted?

1. Yes
2. No
7. Don't know/Not sure
9. Refused

D.10 Some cities and towns are considering laws that would make restaurants smokefree; that is eliminating all tobacco smoke from restaurants. Would you support such a law in your community?

1. Yes
2. No
7. Don't know/Not sure
9. Refused

D.11 If there were a total ban on smoking in restaurants, would you eat out more, less, or would it make no difference?

1. More
2. Less
3. No difference
7. Don't know/Not sure
9. Refused

D.12 If someone were smoking near you in the nonsmoking area of a restaurant, you would ask them to stop.

1. Yes
2. No
3. Maybe
7. Don't know/Not sure
9. Refused

D.13 In the past 12 months, have you ever asked a stranger not to smoke around you, in order to avoid exposure to their tobacco smoke?

1. Yes
2. No
7. Don't know/Not sure
9. Refused

RKM.11 In the past 12 months, have you ever asked someone you know not to smoke around you, in order to avoid exposure to their tobacco smoke?

1. Yes
2. No
7. Don't know/Not sure
9. Refused

RKM.12 In the past 12 months, have you encouraged anyone you know to not start, or to stop using, tobacco Products?

1. Yes
2. No
7. Don't know/Not sure
9. Refused

Section 5: Risk Perception and Social Influences

I am going to read a statement. I want you to tell me whether you strongly agree, agree, disagree, or strongly disagree with this statement.

29. If a person has smoked a pack of cigarettes a day for more than 20 years, there is little health benefit to quittting smoking.

1. Strongly agree
2. Agree
3. Disagree
4. Strongly disagree
7. No opinion/Don't know
9. Refused

E.3 Smoking is physically addictive

1. Strongly agree
2. Agree
3. Disagree
4. Strongly disagree
7. No opinion/Don't know
9. Refused

E.4 Smoking light cigarettes is safer than smoking regular cigarettes

1. Strongly agree
2. Agree
3. Disagree
4. Strongly disagree
7. No opinion/Don't know
9. Refused

E.5 Smoking by a pregnant woman may harm the baby.

1. Strongly agree
2. Agree
3. Disagree
4. Strongly disagree
7. No opinion/Don't know
9. Refused

Now I am going to ask about smoke from other people's cigarettes.

RKM.5. It is acceptable for an adult to smoke cigarettes when they are around an adult non-smoker.

1. Strongly agree
2. Agree
3. Disagree
4. Strongly disagree
7. No opinion/Don't know
9. Refused

RKM.6. It is acceptable for an adult to smoke cigarettes when they are around children.

1. Strongly agree
2. Agree
3. Disagree
4. Strongly disagree
7. No opinion/Don't know
9. Refused

RKM.7. It is acceptable for a woman to smoke cigarettes when she is pregnant.

1. Strongly agree
2. Agree
3. Disagree
4. Strongly disagree
7. No opinion/Don't know
9. Refused

RKM.8. I support efforts to encourage people to not use tobacco products?

1. Strongly agree
2. Agree
3. Disagree
4. Strongly disagree
7. No opinion/Don't know
9. Refused

31. Do you think that breathing smoke from other people's cigarettes is:

1. Very harmful to one's health
2. Somewhat harmful to one's health
3. Not very harmful to one's health
4. Not harmful at all to one's health
7. No opinion/Don't know
9. Refused

32. Would you say that breathing smoke from other people's cigarettes causes:

a. Lung cancer in adults
b. Heart disease in adults
c. Colon cancer
d. Respiratory problems in children
e. Sudden infant death syndrome

1. Yes
2. No
7. Don't know/Not sure
9. Refused

NH 2. Out of every 10 New Hampshire high school students, how many do you think currently smoke?

Number ___
7. Don't know/Not sure
9. Refused

NH 3. Out of every 10 New Hampshire adults over the age of 18, how many do you think currently smoke?

Number ___
7. Don't know/Not sure
9. Refused

Section 6: Policy Issues

F.8.a How much additional tax on a pack of cigarettes would you be willing to support if some or all the money raised was used to fund tobacco prevention programs?

1. Less than $1.00 a pack→ Go to F.8.b
2. $1.00 a pack or more→ Skip to F.8.c
3. No tax increase→ Section G
7. No opinion/Don't know→ Section G
9. Refused → Section G

F.8.b Do you think it should be

1. $.25 a pack
2. $.50 a pack
3. $.75 a pack
7. No opinion/Don't know
9. Refused

F.8.c Do you think it should be

1. $1.50 a pack
2. $2.00 a pack
3. $3.00 a pack
7. Refused
9. No opinion/Don't know

Section 7: Parental Involvement

If Q34b + Q34c = 0 then go to Section H.

Now, I want you to think of the child in your household who is nearest to the age of 10.

G.1 What is the age of the child nearest to age 10?

___ ___

G.2 Is that child a boy or a girl?

1. Male
2. Female

G.3 What is your relationship to that child?

1. Father or stepfather
2. Mother or stepmother
3. Brother
4. Sister
5. Grandmother
6. Grandfather
7. Other relative
8. Unrelated child

During the last 6 months, how many times have you:

G.4 Talked to your child about what he/she can or cannot do when it comes to tobacco?

1. Never
2. Once
3. Twice
4. Three or more times
7. Don't know/Not sure
9. Refused

G.5 Told your child he/she cannot use tobacco?

1. Never
2. Once
3. Twice
4. Three or more times
7. Don't know/Not sure
9. Refused

G.6 Do you think your child smokes?

1. I am certain that my child does not smoke
2. I don't think that my child smokes
3. I don't know if my child smokes or not
4. I suspect that my child smokes
5. I am certain that my child smokes
9. Refused

G.7 How much would you like it or dislike it if you found your child smoking cigarettes now? Would You…

1. Like it a lot
2. Like it some
3. Neither like it nor dislike it
4. Dislike it a lot
7. Don't know/Not sure
9. Refused

G.8 Does your child have to be home by a certain time on school nights?

1. Yes
2. No
3. Never away from home on school nights
7. Don't know/Not sure
9. Refused

G.9 Does your child have to be home by a certain time on weekend nights?

1. Yes
2. No
3. Never away from home on weekend nights
7. Don't know/Not sure
9. Refused

Section 8: Media Exposure

H.1 During the past 7 days on average, how many hours a day did you:

ENTER TIME TO NEAREST HALF HOUR:

a. Watch television ____
b. Listen to the radio ____
c. Browse or surf the internet ____

H.2 During the past 7 days, how many commercials have you seen on TV about NOT smoking cigarettes?

0. None
1. One
2. Two or three
3. Four to six
4. Seven or more
7. Don't know/Not sure
9. Refused

H.3 During the past 7 days, how many commercials have you heard on the radio about NOT smoking cigarettes?

0. None
1. One
2. Two or three
3. Four to six
4. Seven or more
7. Don't know/Not sure
9. Refused

NH.4 During the past 7 days, how many messages have you seen on billboards, posters, or other printed materials about NOT smoking cigarettes?

0. None
1. One

2. Two or three
3. Four to six
4. Seven or more
7. Don't know/Not sure
9. Refused

Section 9: Closing Demographic Items

33. What is your age?

___ ___ Code age in years

7. Don't know/Not sure
9. Refused

35. Are you Hispanic or Latino?

1. Yes
2. No
7. Don't know/Not sure
9. Refused

36. Which one or more of the following would you say is your race?

1. White
2. Black or African American
3. Asian
4. Native Hawaiian or Other Pacific Islander
5. American Indian, Alaska Native
6. Other [specify:] _____
7. Don't know/Not sure
8. No additional choice
9. Refused

If more than one response to Q36, (or Q36 = 6, 7, or 8) continue to Q37. Otherwise, go to Q38.

37. Which one of these groups would you say best represents your race?

1. White
2. Black or African American
3. Asian
4. Native Hawaiian or Other Pacific Islander
5. American Indian, Alaska Native
6. Other [specify:] _____
7. Don't know/Not sure
9. Refused

38. Are you:

1. Married
2. Divorced

3. Widowed
4. Separated
5. Never married or
6. A member of an unmarried couple
9. Refused

39. What is the highest level of school you completed or the highest degree you received?

1. Never attended school or only attended kindergarten
2. Grades 1 through 8 (Elementary)
3. Grades 9 through 11 (Some high school)
4. Grade 12 (High school graduate)
5. GED
6. Some College, no degree
7. AA, Technical/vocational
8. AA, Academic
9. BA,BS (college graduate)
10. At least some graduate or professional school
77. Don't know
99. Refused

40. Is your annual household income from all sources:

0 4 Less than $25,000 ($20,000 to less than $25,000)
0 3 Less than $20,000 ($15,000 to less than $20,000)
0 2 Less than $15,000($10,000 to less than $15,000)
0 1 Less than $10,000
0 5 Less than $35,000 ($25,000 to less than $35,000)
0 6 Less than $50,000 ($35,000 to less than $50,000)
0 7 Less than $75,000 ($50,000 to less than $75,000)
0 8 $75,000 or more
7 7 Don't know/Not sure
9 9 Refused

41. Indicate sex of respondent. Ask only if necessary

1. male
2. female